

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency



Administrative Issuance: CFSA-09-10

To: All CFSA Staff

From: Roque R. Gerald, Psy.D.
Acting Director

Date: June 8, 2009

Re: Service Referrals for High and Intensive Risk Families with Unfounded or Inconclusive Allegations

In accordance with District and Federal law, the Child and Family Services Agency (CFSA) is responsible for the receipt of and response to any complaint or report of child maltreatment (abuse and neglect) of any child/ren in the District of Columbia. In the event that an investigation does not reveal evidence of child maltreatment, it is nonetheless essential for the Child Protective Services (CPS) investigator to assess risks and needs for the safety and well-being of the child/ren. As always, it is the ultimate objective of the CPS investigator to protect children by stabilizing and strengthening families whenever possible and to help caregivers carry out their responsibilities effectively, either through direct or purchased services.

Experience has revealed that recurrence of maltreatment, subsequent injury and/or removal of the child/ren from home can be prevented when CPS social workers access services for high or intensive risk families.

This administrative issuance provides guidance to CPS investigators whose investigations have resulted in unfounded or inconclusive reports and yet, as a result of the assessed high or intensive risk for the investigated families, may still require a set criteria and process for offering CFSA services. *(The process for families with high or intensive risk with substantiated reports is not incorporated in this administrative issuance. See Investigations Policy, Procedure C. Any family with a substantiated allegation shall have a case opened with the Agency.)* If you have any questions regarding this administrative issuance, please contact the Deputy Director for Program Operations.

Criteria

The following criteria must be met prior to CPS referral of a high or intensive risk family for CFSA services:

1. Completed abuse or neglect investigation.
2. Investigation findings are unfounded or inconclusive.
3. All children remain in the home.
4. No Abuse or Neglect legal proceedings.
5. The initial Structured Decision Making (SDM) risk assessment tool scores the family as high or intensive risk *(See Investigations Policy, Attachment B, Assessment Criteria)*.
6. The caretaker agrees to services and has signed the Authorization to Refer and Disclose Information to Child and Family Services Agency.
7. All overrides from an SDM moderate risk assessment to a high risk must be approved by a CPS program manager.

Referral Process

1. For completed investigations that meet the criteria listed above, the CPS investigator shall advise the family of available CFSA services and assist the family in completing the Authorization to Refer and Disclose Information (Attachment A).
2. The CPS investigator shall advise the client that participation with CFSA services is voluntary and that the client has the right to refuse services. The investigator shall discuss and review the Authorization and Consent to Receive Services Form with the client (*see Attachment B*).
3. If the client refuses services, the investigation shall be closed; the appropriate information shall be documented in FACES, and case files shall be processed and stored in accordance with *Administrative Issuance CFSA-08-5, Central Files Unit and Records Management Procedures*.
4. If the client accepts services, the investigation shall be connected to a case, a case record shall be developed and the case shall be posted for assignment in accordance with procedures outlined in *Administrative Issuance CFSA-09-5, Case Transfers from Child Protective Services (CPS)*.
5. All referrals shall be submitted to the CPS supervisor for review and approval.
6. All referrals shall be documented as appropriate in FACES.

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ATTACHMENT A

**Authorization to Refer and Disclose Information to
Child and Family Services Agency**

***Si usted no entiende el idioma Inglés, favor de pedir esta forma en Español**.*

Instructions

- The “Authorization to Refer and Disclose Information to Child and Family Services Agency (CFSA)” (Authorization) is used by CFSA staff to authorize the referral of a client to an administrative division of the CFSA without opening a child abuse and neglect case in the District of Columbia for services. It also permits CFSA to provide non-health related information about the client to the administration.
- The Authorization may be signed by an individual who is referred for individual services (for example, a former foster child who aged out of foster care) or by a parent or guardian on behalf of herself/himself and the minor children. If there are questions about who can sign, contact the Office of the General Counsel.
- If medical or dental information also needs to be sent to the administration, use the “Authorization to Disclose Medical or Dental Information” to permit that disclosure. Similarly, if mental health or substance abuse information also needs to be sent to the administration, use the “Authorization to Disclose Mental Health and Substance Abuse Information”.
- If the client is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization.
- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, as long as the client signs or marks the Authorization.
- The Authorization must be witnessed by the CFSA CPS investigator.
- When the case is sent to the In-Home and Reunification Services Administration, the signed and witnessed Authorization should be sent along with the completed “Case Referral Form”.

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**Authorization to Refer and Disclose Information to
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See Attached Instructions

I. Referral to CFSA

1. I, _____, hereby authorize the Child and Family Services Agency (CFSA) to refer
Name of Individual, Parent or Guardian
the individuals named below to the CFSA In-Home and Reunification Services Administration.

2. The purpose of the referral is: _____

_____.

II. Individual(s) being Referred *If additional individuals are being referred; please identify them on Attachment A. This includes identifying the spouse/significant other and all children in the family who are being referred.*

1. Name: _____
Last First Middle
D.O.B. _____ Social Security No. _____ -- --
Race: _____ Gender: Male Female (Circle One)
Current Address: _____
No. & Street City State zip code Dates of Residency
Telephone Number: _____

III. Information to be Released *Use additional pages if necessary.*

1. To enable the In-Home and Reunification Services Administration to serve me/us, I/we further authorize CFSA to disclose information as follows:

_____.

IV. Signature

- I understand that this Authorization to Refer and Disclose Information to CFSA (Authorization) permits the release of both oral information and documents.
- I understand that this Authorization shall allow Child and Family Services Agency to provide services for my family to reduce any risk to my child/ren's safety and well-being, and does not open a child abuse or neglect case under my name or my child/ren's names in the District of Columbia.
- I understand that the information used or disclosed on the basis of this Authorization may not be disclosed again by the recipient except by my express authorization or otherwise in accordance with applicable law.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency

Attn: _____, Investigator

400 6th Street S.W.

Washington, DC 20024

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reference to this Authorization before it received written notice of my revocation.
- I understand that this Authorization will expire six (6) months from the date on which I sign it, and that I may sign a new Authorization for an additional six (6) month period.
- I have received a copy of this Authorization.

Individual's Signature

Date

Name printed

Address: _____

Telephone Number: _____

Relationship to persons named in Part II: Parent Legal guardian Self (if over 18 years of age) *Note: if not the parent, legal guardian or self (and over 18 years of age), discuss with the Office of the General Counsel*

Witness: _____

Investigator's Signature

Investigator's Name Printed

Attachment A: Individual(s) being Referred Continuation Sheet
Authorization to Refer and Disclose Information to CFSA

II. Individual(s) being Referred *If additional individuals are being referred, please identify them on Attachment A. Use as many sheets as needed.*

2. Name: _____

Last

First

Middle

D.O.B. _____

Social Security No. _____ -- _____ -- _____

Race: _____

Gender: Male Female (Circle One)

Current Address: _____

No. & Street

City

State

zip code

Dates of Residency

Telephone Number: _____

3. Name: _____

Last

First

Middle

D.O.B. _____

Social Security No. _____ -- _____ -- _____

Race: _____

Gender: Male Female (Circle One)

Current Address: _____

No. & Street

City

State

zip code

Dates of Residency

Telephone Number: _____

4. Name: _____

Last

First

Middle

D.O.B. _____

Social Security No. _____ -- _____ -- _____

Race: _____

Gender: Male Female (Circle One)

Current Address: _____

No. & Street

City

State

zip code

Dates of Residency

Telephone Number: _____

5. Name: _____

Last

First

Middle

D.O.B. _____

Social Security No. _____ -- _____ -- _____

Race: _____

Gender: Male Female (Circle One)

Current Address: _____

No. & Street

City

State

zip code

Dates of Residency

Telephone Number: _____

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ATTACHMENT B
Authorization for Consent to Receive Services

I, _____, acknowledge that I have been informed that CFSA has determined that there is NO FINDING OF ABUSE OR NEGLECT of my child(ren) _____, _____, _____. Although there is no finding of abuse or neglect, I understand that I may still choose to receive services from CFSA that are needed, identified, and agreed upon between myself and the CFSA investigator or I may choose to decline these same services from CFSA.

I also understand that the agreement to receive services is voluntary, and that I have the right to refuse services from CFSA at any time. If I do start to receive services as needed, identified, and agreed upon between myself and the CFSA investigator, but then later choose to stop receiving those same services, I have the option of signing my name below to attest to my decision *even though my signature is not mandatory or necessary*. I am aware that I can discontinue receiving services at any time without signing this or any other document.

I agree to voluntarily receive services from CFSA only for the purposes described above.

Printed Name of Caregiver

Signed Name of Caregiver

Date

I DO NOT agree to receive services from CFSA and I understand that by signing my name below, CFSA shall not provide services. If I have started to receive services from CFSA but do not wish to continue receiving services, I understand that by signing my name below, the services shall stop.

Printed Name of Caregiver

Signed Name of Caregiver

Date

FOR CFSA USE ONLY:

I have discussed possible services and reviewed this form with the client listed above.

Signature of CPS Investigator

Date

_____declined services and refused to sign this form.
Client's Name

_____received services but declines continuation of services and refused to sign this form.
Client's Name